# NEW PATIENT FORM

## General Information

Legal Name:______________________________________________

Preferred Name: ____________________ DOB:________________ SSN: ________________

Address:______________________________________________

City:______________________________ State:________________ Zip: ____________

Primary Phone:__________________________ Other Phone: ________________________

Email Address: ______________________________________________

If you gave us your email, would you like signed up for the portal (check one): YES NO

Are you (check one): Employed Retired Student Other

Employer: __________________________ Work Phone: ____________________

**Emergency Contact Information** *(informational only; this does not grant access to your PHI/protected health information)*

Name: ____________________________ Phone: ______________________

Relationship: ________________________

**Medical Information**

Who is your primary care physician: ______________________________________

What pharmacy do you use: ____________________City:____________________

**Insurance Information**

Name of your insurance company(s): ______________________________________

Signature: ____________________________________ Date: ____________________